PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING _____ B. WING _____	08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 26 4. Resident #13 was admitted to the facility on March 31, 2006, with diagnoses of Muscle Weakness, Diabetes Mellitus, Depressive Disorder, Esophagitis Reflux, Congestive Heart Failure, and Obesity. Review of resident #13's Resident Assessment Protocol (RAP) Summary dated December 14, 2009, revealed resident #13 was assessed to require a scheduled toileting program for bowels. The quarterly Interdisciplinary Care Plan Conference Meeting dated June 9, 2010, revealed resident #13 remained on the scheduled toileting program for bowels. Further record review of resident #13's care plan updated June 16, 2010, revealed the resident continued on a scheduled toileting program instructing staff to toilet resident #13 before lunch and supper and at bedtime. An interview conducted on August 12, 2010, at 3:30 p.m., with CNA #6 revealed resident #13 was incontinent of bowel at times and at other times was aware and would ring for assistance. CNA #6 revealed the CNA was unaware that resident #13 was on a scheduled toileting program. CNA #6 recalled that resident #13 had been on a scheduled toileting program some time ago but was sure it had been discontinued. CNA #6 stated she received updates about resident care needs through the KIOS system. CNA #6 was sure she received a message some time ago (unable to remember exact date) to discontinue the scheduled toileting program for resident #13 because the resident was nonambulatory. CNA #6 revealed the nurse aide care plan was not updated with the change in the toileting program. An interview conducted on August 12, 2010, with	F 282		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING _____ B. WING _____	08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 27 resident #13 revealed the CNAs took him/her to the bathroom when the resident requested to go. Resident #13 stated a CNA took the resident to the bathroom before breakfast but not before lunch. An interview conducted on August 12, 2010, at 6:35 p.m., with the DON revealed the CNAs were responsible to provide resident care according to the nurse aide care plan. The DON stated the nurse aide care plans were updated in red ink denoting any changes. The DON stated CNAs could receive resident care updates via the KIOS system but could not recall any updated care needs for resident #13.	F 282	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.*	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure incontinent residents received the appropriate treatment and services to restore as much normal bladder function as possible for two (2) of twenty (20) sampled residents. Residents #9 and #11 had been assessed to require an individualized	F 315	F – 315 1. The toileting plans for residents #11 and #9 were reviewed on September 7, 2010 by ADON and any updates were made as needed. The care plans and NACP were reviewed and updated as needed. These care plans were reviewed with each oncoming shift X 6 shifts to ensure communication of the plan to the SRNA. 2. The toileting programs for all residents will be reviewed by ADON by 9/8/2010 and any changes or updates will be made. All care plans and NACP will be updated in red to highlight these changes. 3. All SRNA's were re-educated on September 13, 2010 by DON regarding the policy of toileting program. All toileting programs are reviewed quarterly to evaluate the effectiveness and appropriateness of the plan. This will continue. 4. The ADON will audit the NACP and d care plan and toileting program for all residents on a toileting	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING _____ B. WING _____	08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 28 toileting program; however, there was no evidence the residents were toileted based on the resident's assessed individual needs The findings include: 1. Medical record review for resident #9 revealed that the resident was admitted to the facility in April 2007 with diagnoses that included Cerebrovascular Accident, Hemiplegia, and Anxiety State. Review of the comprehensive assessment dated March 31, 2010, revealed that resident #9 had been assessed to experience daily incontinence episodes while demonstrating some bladder control. Review of the Resident Assessment Protocols (RAPs) for urinary incontinence revealed that resident #9 was frequently incontinent, was on a scheduled toileting program, and would continue with this program. The Nursing Care Plan updated June 30, 2010, stated the resident was on a scheduled toileting program: toilet after lunch, before and after supper, at bedtime, and at least one throughout the night. The Nurse Aide Care Plan (no date) revealed "scheduled toileting" for resident #9. Interviews conducted on August 11, 2010, at 3:40 p.m., with Certified Nursing Assistant (CNA) #3 revealed that the CNA was not familiar with the scheduled toileting program. The CNA stated that he took almost everyone to the toilet or changed wet briefs every two hours, and waited for resident #9 to call for assistance for toileting. CNA #3 further stated he believed resident #9 was aware of the need to toilet. The CNA stated he did encourage resident #9 to ring out when the resident needed to toilet. However, the CNA	F 315	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies.* *Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.* *Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.* *To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* program monthly X3 months then quarterly to ensure that a program is being followed. Her audits will be presented to the facility Quality Assurance committee for review. 5. Date of Completion:	9/13/2010

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING _____ B. WING _____	08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 29 stated he was unaware of a scheduled toileting program for resident #9. The CNA stated he had been assigned to care for resident #9 for approximately the past three weeks and had not provided a toileting program for resident #9. Additional interview conducted with the Director of Nursing (DON) on August 12, 2010, at 6:30 p.m., revealed the DON was responsible for resident assessments and the DON stated resident #9 was assessed and care planned for a toileting program. 2. Resident #11 was observed on August 12, 2010, at 11:50 a.m., sitting in a wheelchair. The resident stated he/she was not always aware of the need to void and used briefs for incontinence management. The resident stated sometimes the resident was able to call staff to assist with using the bathroom facilities. A review of the admission comprehensive assessment completed on May 4, 2010, revealed resident #11 was assessed to require extensive assistance with transfers and toileting and to be frequently incontinent of bowel/bladder. A review of the bladder assessment conducted on April 22, 2010, revealed resident #11 was assessed to have urge/functional incontinence, and a three-day elimination pattern was to be monitored to assess the resident for a scheduled toileting program. A review of the results of the three-day pattern revealed resident #11 was occasionally incontinent with some pattern of elimination noted. The resident was placed on a scheduled toileting program on April 29, 2010, and was to be toileted upon arising, before/after meals, and at bedtime.	F 315		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING _____ B. WING _____	08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 30 Interviews conducted with CNAs #3 and #4 on August 12, 2010, at 2:30 p.m., and at 2:45 p.m., revealed the CNAs were not aware resident #11 was to be on a scheduled toileting program. The CNAs stated the incontinence rounds were conducted every two hours and resident #11 was usually incontinent during these rounds. A review of the Bowel/Bladder detail report dated July 14, 2010 through August 12, 2010, revealed documentation that resident #11 had been toileted per staff only five times in July 2010 (July 18, 2010, at 2:22 p.m. and 9:46 p.m., July 19, 2010, at 12:23 p.m., July 21, 2010, at 9:16 p.m., and July 23, 2010, at 9:10 p.m.). During August 2010 staff documented resident #11 was toileted four times (August 1, 2010, at 3:02 p.m., August 9, 2010, at 7:35 p.m., August 11, 2010, at 9:03 p.m., and August 12, 2010, at 10:17 a.m.). An interview conducted with RN #4 on August 12, 2010, at 5:20 p.m., revealed the RN monitored the CNAs during incontinence rounds and reminded the CNAs of residents who had been assessed to require a toileting program. A review of the facility's policy regarding Bowel/Bladder (dated January 1, 2009) revealed residents who had been assessed with bladder incontinence would be evaluated for appropriate services to restore or maintain as much normal function as possible. The policy further noted interventions would be implemented to achieve the highest practical level of continence for the residents. An interview conducted with the Director of Nurses (DON) on August 12, 2010, at 6:30 p.m.,	F 315		

PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING _____ B. WING _____	08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 31 revealed the CNAs were responsible to provide the toileting schedule which had been developed as a result of the bladder assessment/pattern. The DON stated in-services related to toileting had been provided for the CNAs and the DON was not aware the CNAs were not providing the toileting program for resident #11.	F 315	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.*	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431	F – 431 1. The Assure 4 solution and Assure Glucose Test strips were taken out of use and destroyed on August 12, 2010. The Director of Plant Operations was notified and the air conditioning was fixed to bring the medication room within compliance on August 12, 2010. The thermometer in the room was replaced on 8-12-10. 2. All other facility medicine storage rooms were checked on 8-12-10 by Director of Plant Operations and no other problems with elevated temperature were noted. 3. A temperature log was placed in each of the medicine storage rooms on 9-13-10 to record the daily temperature. This is to be recorded daily by the station charge nurse. Any temperatures outside of acceptable range are to be addressed immediately. 4. The temperature logs will be monitored weekly	

Received Time Sep. 8. 2010 10:37AM No. 2596

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING _____ B. WING _____	08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 32 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure biologicals were stored safely and at the appropriate temperatures. Test strips and control solution used for the Glucometer machines were observed to be stored in the medication room on the Willow Brook Hall at improper temperatures. The findings include: Observation of the Willow Brook Hall Medication Storage Room on August 12, 2010, at 5:00 p.m., revealed the thermometer on the wall of the medication room indicated the room temperature was 90 degrees Fahrenheit. Further observation of the medication room revealed one bottle of Assure 4 solution (used to check the controls on the Glucometer machine) was stored in a plastic container in the medication room. According to the label, the control solution was to be stored between 59 and 86 degrees Fahrenheit. In addition, 10 boxes of Assure 4 Glucose Test Strips were stored in a plastic container in the medication room. The box label indicated the test strips were to be stored between 40 and 86 degrees Fahrenheit. An interview conducted with Certified Medication Technician (CMT) #2 on August 12, 2010, at 5:05 p.m., revealed the facility did not routinely monitor the temperature of the medication room. The	F 431	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.* *Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.* *To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* X4 weeks then monthly by Director of Plant Operations. Any problems not addressed when found will be referred to the facility QA committee for action. 5. Date of Completion: 9/17/2010.	

PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING _____ B. WING _____	08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 33 CMT stated the room temperature had been elevated a couple of weeks ago and the maintenance staff had corrected the temperature. The CMT stated the room temperatures had not been monitored to ensure the temperatures were appropriate. An interview conducted with the Maintenance Supervisor (MS) on August 12, 2010, at 5:10 p.m., revealed the medication room had been identified to be too warm approximately two weeks ago. The MS stated a problem related to a duct in the attic of the facility had been corrected. The MS stated medication room temperatures were not routinely monitored and no temperatures had been monitored after the problem had been identified two weeks earlier to ensure appropriate temperatures were maintained. A review of the facility's policy/procedure related to medication/biologicals storage (dated September 2008) revealed medications requiring storage at room temperatures are kept at temperatures in accordance with the manufacturer's specifications.	F 431	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* F-441 1. Tub was cleaned on 8-13-10 by SRNA. 2. All staff were in serviced on the use of gloves as soon as we were notified of the alleged non-compliance. The DON & ADON observed staff on all 3 shifts perform g-tube feedings, accuchecks, wound care and skin assessments each day for 3 days and corrected any non compliance prior to resident contact to ensure no other resident was affected. The tub is to be cleaned daily by housekeeping.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441	3. A skills checklist that includes hand washing, wound dressing, and g-tube feedings, accuchecks will be used to ensure education on the use of gloves in standard precautions. All nurses will be checked off by 9-14-10 and then annually. This checklist will be utilized for orientation of all newly hired nurses. Representative of TechCo (c-tub distributor) is scheduled on 9/7/10 to in-service all staff on when and how to clean century tub.	

PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING _____ B. WING _____	08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 34 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility policy, it was determined the facility failed to maintain an effective infection control program. Observation of medication administration on August 11, 2010, revealed staff failed to wear gloves during administration of medications via a gastrostomy tube (g-tube) and while performing accuchecks. The staff failed to wash hands after removing gloves during wound care and failed to change gloves during a skin assessment. Additionally,	F 441	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* 4. The Director of Housekeeping will check the tub daily X2 weeks then weekly to ensure the cleaning is being done as assigned. DON will audit the skills checklist of all new employees monthly X3 months then quarterly to ensure the appropriate education took place and will review all current nurses on 9-14-10 to ensure all current nurses have been educated. The checklist will be part of the employee file. Audits done quarterly to ensure continued compliance. These audits are reviewed no less than quarterly by the facility QA committee. 5. Date of Completion: 9/17/2010.	

Received Time Sep. 8. 2010 10:37AM No. 2596

PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING _____ B. WING _____	08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 35 the whirlpool tub on the Oaklawn Unit was observed to be soiled and was not cleaned after resident use. The findings include: 1. Observation on August 11, 2010, during morning medication pass revealed LPN #1 prepared eight medications for administration per g-tube to resident #2. LPN #1 exposed resident #2's abdomen, turned off the g-tube feeding pump, disconnected the g-tube feeding, and administered the medications via the g-tube without wearing gloves. Interview on August 11, 2010, at 11:00 a.m., with LPN #1 revealed the LPN failed to wear gloves during resident #2's g-tube medication administration and stated gloves should be worn during resident contact. Review of the facility's policy from Lippincott, 2001, page 759, revealed standard precautions recommend that wearing gloves was indicated for any known or anticipated contact with blood, body fluids, tissue, mucous membrane, and nonintact skin. 2. Observation on August 11, 2010, at 10:20 a.m., revealed RN #1 provided wound care to resident #3. RN #1 removed a soiled dressing from resident #3's right foot. RN #1 removed gloves after removing the soiled dressing and donned a second pair of gloves but failed to wash hands after removing the soiled gloves. Interview on August 11, 2010, at 10:45 a.m., with RN #1 revealed the RN was not knowledgeable of the recommendation that hands should be	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING _____ B. WING _____	08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 36	F 441		

washed between glove changes. RN #1 stated the RN was aware the facility refers to the Lippincott as a policy/procedure manual but was not aware it directed staff to wash hands after removing gloves.

Review of the facility's policy from Lippincott, 2001, page 378, revealed hands should always be washed after removing gloves.

3. Observation on August 11, 2010, at 1:30 p.m., on the Willow Brook Wing revealed LPN #2 performed an accucheck for resident #18; however, LPN #2 failed to wear gloves.

An interview conducted on August 11, 2010, at 1:40 p.m., with LPN #2 revealed the LPN should have worn gloves when accuchecks were performed. LPN #2 stated the LPN knew to wear gloves when performing accuchecks for the protection of herself and the residents. LPN #2 stated the LPN was just in a hurry because the resident thought her blood sugar was low.

4. During observation of a skin assessment on resident #5 on August 11, 2010, at 2:45 p.m., RN # 1 donned gloves to perform the skin assessment. RN #1 removed a soiled transparent dressing from a blistered area. RN #1 continued with the skin assessment and direct contact with resident #5's reddened peritoneal area. RN #1 adjusted the resident's privacy curtain with the soiled gloves and opened the drawer of resident #5's bedside table. RN #1 removed a protective ointment from the resident's drawer and applied the protective ointment to resident #5's peritoneal area with the same gloves. RN #1 opened the bedside table drawer again with soiled gloved hands and obtained an

PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING _____ B. WING _____	08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 37 incontinence brief. An interview with RN #1 on August 11, 2010, revealed the RN should have changed soiled gloves prior to touching the resident again or anything in the resident's room. RN #1 stated the RN knew to change gloves but just got nervous and forgot. 5. During several observations on August 10, 2010, at 1:05 p.m., August 11, 2010, at 4:45 p.m., and August 12, 2010, at 2:50 p.m., the residents' shower room whirlpool tub was observed soiled with soap scum rings around the sides of the tub. An interview conducted on August 10, 2010, at 3:40 p.m., with Housekeeping Supervisor revealed the housekeeping staff was not responsible for cleaning the residents' whirlpool tub. The CNAs were responsible for cleaning the whirlpool tub when used for the residents. An interview conducted on August 12, 2010, at 2:50 p.m., with CNA #6 revealed the CNA is responsible for cleaning the residents' whirlpool tub before and after every resident use. CNA #6 stated she last used the whirlpool tub on July 31, 2010. The tub was cleaned with CDC wipes before and after resident use. CNA #6 stated she cleaned the tub after resident use. CNA #6 stated the tub was "very dirty." An interview conducted on August 12, 2010, at 3:45 p.m., with LPN #1 revealed the CNA is responsible for cleaning the residents' whirlpool tub before and after resident use. LPN #1 stated the "tub is very dirty." LPN #1 stated, "it is my responsibility to monitor residents' care."	F 441		

Received Time Sep. 8. 2010 10:37AM No. 2596

PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING _____ B. WING _____	08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 38 An interview conducted on August 12, 2010, at 6:35 p.m., with the Director of Nursing (DON) revealed the CNA is responsible for cleaning the residents' whirlpool tub before and after each resident use. The DON stated the facility does not have a policy in place for cleaning the residents' whirlpool tub. The DON added the facility is in the process of hiring an Infection Control Nurse.	F 441	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.*	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. The drywall was torn/chipped/stained in resident rooms and showers. Resident shower tile was stained and discolored. The Oak Lawn Wing carpet was soiled and stained after repeated cleaning. Ceiling light fixtures and attic space entrances were dusty and dirty. The findings include: Observation of the facility during the environmental tour on August 10-12, 2010, revealed the following items were in need of maintenance/repair/cleaning: -Drywall and molding was torn and loose from the	F 465	F – 465 1: The drywall will be cut out and replaced and painted and new covebase will be applied by 9/20/2010; re-grouted, repaired and cleaned tile in Willowbrook and Oaklawn shower rooms 8/10/2010; Whirlpool tub cleaned and sanitized 8/12/2010; Tile replaced in Willowbrook shower room 8/30/2010; Chest of drawers in rm.#137 was removed 8/10/2010; Broken floor tile near exit door of Willobrook hall replaced 8/30/2010; Drywall behind the head of the bed in rm.#4 repaired 8/11/2010; Drywall above air conditioner in rm.#15 to be repaired by 9/23/2010; Black debris in ceiling light fixtures on Willowbrook and Oaklawn halls cleaned 8/16/2010 and 8/19/2010; Black smears on attic openings on Willowbrook and Oaklawn halls primed and painted 8/28/2010; Ceiling vents on Willowbrook and Oaklawn halls were cleaned 8/11/2010; Corner strips for Willowbrook	

PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING _____ B. WING _____	08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 39 wall near the floor in room 112, -Resident shower rooms on the Willow Brook Wing and Oak Lawn Wing had black stains on tiles and grout, and the grout was loose and peeling, -The resident whirlpool tub located in the Oak Lawn Wing shower room was dirty with soap scum rings around tub sides, -Tile was missing from the shower floor on the Willow Brook Wing, -The chest of drawers had a corner chipped and splintered in room 137, -Floor tile was broken near the exit door of the Willow Brook hallway, -Drywall behind the head of the bed was cracked and peeling in resident room 4 and above the air conditioner unit in resident room 15, -Ceiling light fixtures (11) located on the Willow Brook and Oak Lawn hallways (6) were observed with black debris in fixtures, -Attic openings in the ceilings located on the Willow Brook and Oak Lawn hallways were observed with black smears, -Ceiling attic vents located on the Willow Brook and Oak Lawn hallways were dusty, -The entrance door to the resident shower room on the Willow Brook Wing was chipped and splintered, -The fire door located on the Willow Brook Wing had chipped and splintered wood, -The Oak Lawn hallway carpet was stained and worn, -Ceiling paint was observed to be chipped and stained above the nurses' desk on the Oak Lawn Wing, and -Exposed auxiliary drain pipe and control knobs were extending from the ceiling to the floor in resident room 16 with direct contact to the resident's bed.	F 465	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* shower room door were ordered 8/30/2010 and to be completed 9/20/2010; The carpet on Oaklawn hall was professionally cleaned 8/23/2010; Ceiling above Oaklawn Nursing desk was repaired and repainted 8/14/2010; Cabinet to enclose the exposed drain pipe in rm.#16 was constructed and put in place 8/31/2010. 2. A facility Environmental audit will be completed by the Director of Environmental Services and Housekeeping staff by 9/15/2010 to identify other areas within the facility in need of repairs. 3. The Shower room cleaning schedule was revised 8/10/2010 . A Carpet cleaning log book was developed 8/11/2010 and all Housekeeping and Laundry staff will be re-trained by 9/15/2010. An Environmental checklist, to include areas cited during the survey, is being developed to monitor the facility for needed repairs. In-service Housekeeping and Laundry staff by 9/15/2010. 4. Housekeeping staff will continue to check all	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING _____ B. WING _____	08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 40 Interview on August 12, 2010, at 4:40 p.m., with the Maintenance Supervisor (MS) revealed the Maintenance Department conducted morning rounds every day to detect any items in need of repair. The MS stated it was the responsibility of all staff to report any items in need of repair. The MS stated the blank work orders were kept near the nurses' desks on each hallway as well as outside his office door so they were easily accessible to all employees. The MS stated items identified had not been reported and apparently had been missed on the daily rounds; however, the MS stated repairs had been made in the resident shower room to remove stained tile and grout. In addition, the MS stated exposed drain pipe and control knobs in room 16 would be addressed and anything that could cause injury to the residents would be a priority. Interview conducted on August 12, 2010, at 4:40 p.m., with the Housekeeping Supervisor (HS) revealed the housekeeping staff was responsible for cleaning of the facility. The HS stated resident showers are cleaned daily per housekeeping staff as well as in between resident use per Certified Nurse Assistant (CNA). The HS further revealed the Oak Lawn Wing carpet is cleaned daily and as needed; however, the stains on the carpet could not be removed with the daily cleaning.	F 465	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* facility areas daily and report all concerns to the Director of Environmental Services and or the Maintenance Director of repairs. Housekeeping staff will audit the facility utilizing the Environmental Checklist weekly X 4, then Monthly X 3 until substantial compliance is noted, and report all areas in need of repair to the Director of Environmental Services and Maintenance director. Findings to be reported to the Quality Assurance Committee quarterly for review. 5. Completion date: 9/20/2010.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the	F 520	F – 520 1. The facility cannot fix the alleged past non-compliance. 2. The DON has audited all current MDSs and compared to the Care Plan to determine the extent of the problem with the accuracy of the MDS	

PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING _____ B. WING _____	08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 41 facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to have an effective Quality Assurance (QA) committee structured to identify quality concerns and develop action plans to correct the concerns identified. The QA committee failed to develop a plan of action to identify the accuracy of resident assessments and plans of care when the Minimum Data Set (MDS) Coordinator was terminated on June 3, 2010, and resident assessments were identified with inconsistencies (refer to F279, F274, and F282). The findings include: Interview on August 12, 2010, at 7:50 p.m., with the Administrator revealed the QA committee met quarterly. The Administrator provided a Payroll	F 520	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* assessments and to ensure all care plans are accurate. This was completed. The results of the audit will be presented to the facility QA committee for review. 3. The facility staff will be re-educated on the QA process to include a review of the facility policy on 9/17/2010 by facility Administrator and DON. 4. The facility QA committee has formed a clinical sub-committee whose members include the facility DON, MDS coordinator, and corporate consultant to complete a review of the facility MDS schedule and assessments, care plans, NA care plans and the MDS assessment function to determine if there are areas that need further review and analysis. This sub-committee is to report to the facility QA committee not later than 9/20/2010 with it's findings and recommendations. The facility QA committee will	

PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING _____ B. WING _____	08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 42 Associate form which revealed the MDS Coordinator was terminated on June 3, 2010, related to violation of company policy and breached code of conduct. The Administrator stated there were concerns with the MDS Coordinator's work performance, tardiness, and relationship with coworkers. The Administrator revealed after terminating the MDS Coordinator, the Director of Nursing (DON) performed the MDS assessments and identified inconsistencies in some of the residents' assessments and care plans. The Administrator stated the DON completed some audits of residents' records; however, the Administrator was not knowledgeable of how many records were audited or the outcome of the audits. The Administrator stated a plan should have been formulated by the QA Committee to perform audits of all resident medical records to ensure accurate assessments had been performed by the terminated MDS Coordinator. The Administrator stated the last QA meeting was conducted on July 23, 2010, however, the Administrator and DON failed to inform the QA Committee of the identified problems with resident assessments and care plans. Interview on August 12, 2010, at 8:00 p.m., with the DON revealed the DON assumed the MDS assessment/care plan responsibilities when the MDS Coordinator was terminated. The DON stated only a few audits were completed because the DON had to focus mainly on completing the assessments/care plans that were due each week. The DON stated during the process of completing the assessments that were due the DON would do a comparison to the previous	F 520	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.* *Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.* *To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* continue to meet no less than quarterly to review any areas of concern brought to the committee's attention. In addition, the committee will implement a review schedule beginning in September to ensure all areas are reviewed systematically and regularly. 5. Date of Completion: 9/20/2010	

PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING _____ B. WING _____	08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 43 assessments to determine the accuracy of the previous assessment. The DON stated the facility had not implemented an action plan to audit all the resident assessments and care plans.	F 520		

PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on August 10, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.*	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to utilize proper access doors and properly seal the fire/smoke wall assembly in the attic area. This deficient practice affected six (6) of seven (7) smoke compartments, staff, and all of the residents. The facility has the capacity for 68 beds with a census of 62 on the day of the survey. The findings include:	K 025	K-025 1. All Fire compartment doors were closed in the attic area 8/11/2010. 2. An inspection of all attic space areas was performed 8/11/2010 by the Maintenance director to identify other breaches in the fire barrier walls. The Maintenance director will check to see if the ductwork in the attic area contains fire/smoke dampers. 3. Four fire doors in the attic area have been identified to be replaced. Estimates were received for the four fire doors, 8/11/2010. All fire doors will be replaced, unsealed penetrations will be sealed; the top of the smoke barrier near rm.#14, along with a large hole in the wall will be replaced and sealed, and the gap around the ductwork near rm#114 by 9/20/2010. All other penetrations will be addressed and sealed per	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 1 During the Life Safety Code survey on August 10, 2010, at 11:25 a.m., with the Director of Maintenance, the attic above the cross corridor doors at room 128 was observed to have an unapproved wooden make shift door in the fire/smoke barrier wall. The door had been left open. Unsealed penetrations of wiring were also observed in the fire/smoke barrier wall. Fire/smoke barrier walls must have proper access doors and penetrations must be filled with a suitable material to prevent the passage of fire and smoke in a fire situation. An interview with the Director of Maintenance revealed outside telephone and heat/air contractors must have done the damage to the fire/smoke barrier wall and left the access door open about two weeks prior. During the survey five other access doors were noted to be left open or missing. The top of the smoke barrier wall was missing near room 14 along with a large hole in the wall. A gap around ductwork was observed near room 114. An interview on August 10, 2010, at 12:00 p.m., revealed the Director of Maintenance was not aware if the ductwork in the attic area contained fire/smoke dampers. The Director of Maintenance was not aware of or did not have access to life safety requirements since being with the facility for about a year and a half. Reference: NFPA 101 (2000 Edition). 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. 8.3.2* Continuity.	K 025	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* NFPA standards as encountered. Estimates for the four fire doors were received and doors ordered. Fire doors received 9/7/2010. The facility has also ordered replacement NFPA Life Safety Manual for the Maintenance director. 4. Facility Maintenance director will visually inspect all attic areas Weekly X 4, then monthly to ensure that all smoke/fire doors are closed and that no new penetrations in the smoke/fire barriers exist. Maintenance director will also perform follow-up visual inspections of the attic areas potentially affected by contractors performing work in the attic space areas. The inspection results will be recorded in the "Fire/Smoke barrier" log. Those areas identified will be	

PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 2 Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose.	K 025	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.* *Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.* *To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* immediately repaired by the Maintenance director / designee. All information will be presented to the Quality Assurance Committee for discussion. 5. Completion date: 9/20/2010	

PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 3 Reference: NFPA 90a (1999 Edition). 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be checked; and moving parts shall be lubricated as necessary.	K 025	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.*	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that hazardous area doors were equipped with a self-closing device. This deficient practice affected five (5) of seven (7) smoke compartments, staff, and approximately fifty (50) residents. The facility has the capacity for 68 beds with a census of 62 on the day of the survey.	K 029	K – 029 1. All doors identified as needing self closures will have self-closures installed by 9/17/2010. 2. A facility audit was performed by the Maintenance Director 8/11/2010 to identify other doors in need of self-closing devices. 3. All doors will be inspected monthly to ensure that self closures are installed and working properly. 4. All doors will be inspected monthly to ensure that self closures are installed and working properly. These audits will become part of the quarterly review by the facility QA Committee. 5. Completion date: 9/17/2010	

PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 4 The findings include: During the Life Safety Code tour on August 10, 2010, at 12:30 p.m., with the Director of Maintenance, a corridor door to the Soiled Linen room was observed not to have a door closing device. Door closing devices are required on doors to rooms deemed to be a hazardous area. An interview revealed the Director of Maintenance was unsure which rooms were considered hazardous that would require a door closing device. During the survey other rooms observed needing door closing devices included but were not limited to the oxygen storage room, Oaklawn supply room, Sprinkler room, and the Medical Records room. Reference: NFPA 101 (2000 Edition). 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms	K 029		

Received Time Sep. 8. 2010 10:37AM No. 2596

PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 5 (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. 19.3.6.3.4 Door-closing devices shall not be required on doors in corridor wall openings other than those serving required exits, smoke barriers, or enclosures of vertical openings and hazardous areas.	K 029	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies.* *Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.* *Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.* *To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* K – 052 1. The areas identified during the survey process were found to be caused by a programming problem and were corrected by Comstar Systems, 9/2/2010. 2. The Comstar company performed a complete check of the facility fire system and found no other areas of concern 9/2/2010. 3. The Comstar company re-in-serviced the Maintenance director 9-2-2010 as to the changes made in the system and certified that the system was working properly as to NFPA standards. 4. The Comstar company will continue to perform inspections of the system and will certify that the system is performing as to NFPA standards. Quarterly fire alarm test will continue by the Maintenance director and any malfunctions in the system will be	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		

PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the building fire alarm system functioned as required by NFPA standards. This deficient practice affected seven (7) of seven (7) smoke compartments, staff, and all of the residents. The facility has the capacity for 68 beds with a census of 62 on the day of the survey. The findings include: During the Life Safety Code tour on August 10, at 3:05 p.m., with the Director of Maintenance, a test of the facility fire alarm system revealed the fire doors would close when the alarm was activated as required but the fire doors could be reset to the open position while the system was still showing trouble conditions. The alarm would reactivate in a short period of time after the fire alarm was silenced. This condition was caused by staff not being able to operate the fire alarm system correctly or by the fire alarm system itself. The fire alarm system should remain silenced to ensure staff can communicate what actions need to be taken in case of an emergency. An interview revealed the Director of Maintenance was not aware the fire doors should not be able to be reset while the fire alarm system was showing trouble conditions. The Director of Maintenance was unsure why the fire alarm system would not remain silenced. Reference: NFPA 72 (1999 Edition). 3-9.6.3 All door hold-open release and integral door release and closure devices used for release	K 052	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* reported immediately to the facility Administrator and to the Comstar company for immediate repairs. 5. Completion date: 9/2/2010	

PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 7 service shall be monitored for integrity in accordance with 3-9.2. 1-5.4.8 Alarm Signal Deactivation A means that is left in the "off" position when there is no alarm shall operate an audible trouble signal until the means is restored to normal.	K 052	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.*	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that oxygen cylinders were stored according to NFPA standards. This deficient practice affected one (1) of seven (7) smoke compartments, staff and approximately ten (10) residents. The facility has the capacity for 68 beds with a census of 62 on the day of the survey. The findings include: During the Life Safety Code tour on August 10, 2010, at 12:15 p.m., with the Director of	K 076	K – 076 1. The combustibles were removed from the oxygen storage room by the Maintenance Director, 8/11/2010. 2. No other areas for storage of facility E-size cylinder tanks are used in the facility. 3. Facility staff will be in-serviced by the DON 9/10/2010 as to the proper storage of Oxygen E-size cylinders within the facility in relation to combustibles. 4. Facility DON / ADON will monitor the Oxygen storage room weekly X 4, then monthly to ensure that the room remains free of combustibles and any problems noted will be reported to QA Committee for review. 5. Completion date: 9/10/2010	